CAMELBACK HEALTHCARE™
COMPLETE CARE FOR YOUR WELL-BEING

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been provided a copy of the HIPAA Notice of Privacy Practices. I also acknowledge that I read and understand the notice, as evidenced by my signature below.

Patient Name: _____

Patient Signature: _____ Date: _____

MEDICAL INFORMATION RELEASE

I give consent to have my medical records made available to the party/parties designated below. This is an authorization with my full understanding that any and all information contained within my medical records is confidential and may contain sensitive data. I understand that I have received and reviewed the Patient Privacy Act in force at Camelback Healthcare. I also understand that if I no longer wish to authorize the release of health information, I must fill out a request in writing.

For results and voice messages, please call: ☐ Home ☐ Cell Phone # _____

If unable to reach me:

Leave a detailed message of my full results_____ OR Leave a message to return your call _____

I authorize Camelback Health Care to release information, including the diagnosis, records and examination rendered to me, as well as claims information. This information may be released to:

Individual's Full Name: _____ Relationship: _____

Individual's Full Name: _____ Relationship: _____

☐ **Information is not to be released to anyone**

Patient Signature or Legal Representative: _____ Date: _____